WELCOME TO
ARROW EYE CARE

PATIENT INFORMATION

Date: _____

Name: _____ Birthdate: _____ Age: _____
Address: _____ City, State: _____ Zip: _____
Hm Phone: _____ Cell Phone: _____ Email: _____ M ___ F ___
Employer / Occupation: _____ Hobbies: _____
Whom may we thank for referring you? _____ Have you been here before? _____

EYE / MEDICAL / SOCIAL HISTORY

What is your reason for today's visit? _____
Date of last eye exam: _____ Eye Doctor: _____ Wears soft contacts____ hard contacts____ glasses____
List all medications you are currently taking: _____
List all medications you are allergic to: _____

Please check all that apply:

Cataracts	___ Me ___ Family	Diabetes	___ Me ___ Family
Macular Degeneration	___ Me ___ Family		___ Insulin ___ Non-insulin
Glaucoma	___ Me ___ Family	Hypertension	___ Me ___ Family
Lazy Eye	___ Me ___ Family	Thyroid Disease	___ Me ___ Family
Eye Injury/Surgery	___ Me ___ Family	Cancer	___ Me ___ Family
Dry eyes	___ Me	Headaches	___ Me

Other conditions _____
_____

** DIGITAL RETINAL PHOTO PLUS OCT SCREENER (Additional $30) -- see next page

Please check one: _____ YES, I wish to have the retinal photo plus OCT.
_____ No, I do not wish to have the retinal photo plus OCT.

** DILATED EYE EXAM (Additional $20)

Dilation involves placing drops in your eyes to enlarge the pupil size, so the doctor can get a better view inside of the eyes. The drops last about 2-4 hours, **temporarily impairs near vision, increases light sensitivity, and in most cases, does not greatly decrease distance vision, but you may need to pay extra attention if you drive afterwards.**

Please check one: _____ YES, I wish to have my eyes dilated if the doctor recommends.
_____ NO, I do not want my eyes dilated. (I assume all risks associated with not dilating eyes.)

** VISUAL FIELD SCREENING (Additional $20)

A computerized instrument checks for loss of sight, both centrally and peripherally. **The test can assist in early detection of glaucoma, retinal problems, neurological diseases and better enables us to diagnose the causes of headaches.**

Please check one: _____ YES, I wish to have the Visual Field Screening.
_____ NO, I do not wish to have the Visual Field Screening.

** PAYMENT (Due as services are rendered)

Vision Insurance: _____ ID#:_____
Policy Holder's Name: _____ M__ F__
Relationship to Patient: Self__ Spouse__ Child__ Other__ SSN: _____ Birthdate: _____
Address (if different): _____ZipCode:_____

I authorize the release of medical information to process insurance claims. I authorize payment of benefits be made directly to Arrow Eye Care for services provided to me. I understand I am financially responsible for charges not covered by this assignment.

**** PLEASE SIGN:** _____ **DATE:** _____

PATIENT PRIVACY NOTICE

Please read a copy of the privacy laws for your information.
By signing below, I have been informed of Arrow Eye Care's Patient Privacy Notice.

**** PLEASE SIGN:** _____ **DATE:** _____